Only one judge dissented in the city health service plan case—Douglas L. Edmonds. He also was among the trio who dissented in the Pacific Health Corporation case, writing the dissent himself.

The majority opinion in the Pacific Health Corporation case held "it is an established doctrine that a corporation may not engage in the practice of such professions as law, medicine or dentistry."

SOCIAL ISSUE

It stated, the health corporation, a San Francisco organization, provided medical, hospital and laboratory service to those belonging for specified charges but offered the services only of a certain approved list of doctors.

After commenting that the question of group medical service had become a social issue the majority opinion stated "there can be no true declaration by this court that a change in social viewpoint now requires the abandonment of the rule against corporate practice of medicine."

POSSIBILITY SEEN

"Such a drastic change," the court ruled, "should come from the Legislature after full investigation and debate.

"It is perfectly possible to bring adequate medical service to the vast numbers of people who now can ill afford it by some means which will protect both the profession and the public from the evils of corporate control . . ."

The opinion termed an "illusory apprehension" the argument that the decision would outlaw fraternal, religious, hospital, labor and similar organization health plans. It pointed out one distinction in these plans, namely, that the public was not directly solicited.

CHIEF JUSTICE CONCURS

The Edmonds dissent, concurred in by Chief Justice William H. Waste and Frederick W. Houser, pointed out that "under the Workmen's Compensation Act, insurance companies, through doctors, are daily providing medical service for thousands of injured employees to the apparent satisfaction of all concerned."

In the city health service decision, the court issued a mandate to City Controller Harold J. Boyd of San Francisco to release to the Health Service Board money already collected, at the rate of $2.50 a month, from nearly 12,000 employees and teachers.

BENEFIT SEEN

In this case the court ruled there was "no question of the power of the city to establish a system of medical service for its employees or their dependents." It reasoned that proper medical attention and the knowledge it would be forthcoming, whenever needed, would have a beneficial effect on the health and efficiency of employee.

Judge Edmonds's dissent countered with the theory that the plan had no direct relation to public health or general welfare, and was nothing more than "social health insurance for a restricted group of individuals." He contended that the majority decision would open the way for city employees to form coöperatives for buying groceries, or meeting any other expense."—Los Angeles *Times*, September 3.

MEDICAL SERVICES TAKE 6 PER CENT OF THE FARM FAMILY LIVING BUDGET

Medical services for the farm family represent about 6 per cent of the cost of all goods and services required for farm family living, according to a recent joint report by the Bureau of Agricultural Economics in coöperation with the Agricultural Adjustment Administration and the Bureau of Home Economics.

Cost of medical services for farm families, it was stated, is equivalent to annual expenditure of about $265,000,000 for the United States, or an average of $39 per farm family. Other medical costs, such as medicine, drugs, health and accident insurance, bring the total bill for farm family medical care to about $350,000,000 a year. That's an average per farm family per year of about $51 or 8 per cent of the average farm family budget.

Farm families generally devote about 85 per cent of their total expenditures for living expenses to the purchase of commodities. The other 15 per cent goes for services of various sorts. Of these, medical services are the most important single group.

The report is the first of a series dealing with prices paid by farmers for services and commodities in the years since 1910. Other reports in this series will deal with prices paid by farmers for machinery, building materials, clothing, food, electricity, and other articles. The series is one part of the income parity study to be used by the Department of Agriculture in administering the Agricultural Adjustment Act of 1938. Other parts of the study are farm income, expenses of agricultural production, and income to farmers from nonfarm sources.

YEAR-TO-YEAR CHANGES SMALL

Medical service rates to farmers do not fluctuate greatly from year to year. They increased 21 per cent, however, from the 1910-1914 period to 1924-1929. In the early thirties the economic recession brought some lowering of rates, but from 1932 to 1935-1936 the average of rates for the country as a whole was unchanged at 16 per cent above the 1910-1914 level. On the other hand, it was pointed out that the increase in medical service rates has been accompanied by an improvement in the quality and availability of medical services. Improved transportation facilities and an increase in the number of hospitals have made medical care more readily available to farm folks.

More farm folks, it was reported, now come to the doctor than in the earlier days of rural health service. Except for this increased efficiency in the use of the doctor's time, it was said, there probably would have been more of an increase in rates for medical services in rural areas during the past twenty-five years.

RATES VARY BY REGIONS

The report also deals in detail with costs of hospital service, fees for physicians, dentists, oculists, and optometrists, and charges for nurses' services. The increase in fees from 1910-1914 to 1935-1936 varied somewhat among the several services. Physicians' fees increased 13 per cent, dentists' fees were up 22 per cent, oculists' and optometrists' fees 14 per cent, hospital charges 17 per cent, and nurses' fees were 23 per cent higher.

During the last decade or more, rates in the New England and Middle Atlantic regions have been maintained at relatively high levels, reflecting, in part, the greater stability of farmers' incomes in these regions. On the other hand, in the West North Central region, where the severe droughts in 1934 and 1936 reduced farm income sharply, rates in 1935-1936 were only 9 per cent above the prewar level.

Index numbers of changes by regions are shown in the following table. In general, medical service rates to farmers and the expenditures for medical services are highest in the Pacific and Mountain states and lowest in the Southern states.

Index Numbers of Fees for Medical Services to Farmers, by Regions, 1910-14, 1924-29, 1932, and 1935-36 (1910-14=100)

Region	1910-14	1924-29	1932	1935-36
New England	100	133	132	133
Middle Atlantic	100	138	133	132
East North Central	100	123	118	119
West North Central	100	117	112	109
South Atlantic	100	121	118	122
East South Central	100	124	121	121
West South Central	100	119	107	111
Mountain	100	116	110	112
Pacific	100	115	113	112
United States	100	121	116	116

In the past, the Bureau of Agricultural Economics has indicated the trend of prices paid by farmers for articles on the basis of prices paid for commodities only. Data on changes in service rates are needed to complete the picture. If provision is made for collecting current data on service rates to farmers, it is stated, these service rates should be combined with commodity prices to form a comprehensive measure of changes in rural living costs.

Since medical service rates have not changed greatly and medical care constitutes less than 10 per cent of the budget, the adding of an index series of these rates to index numbers of prices paid by farmers for commodities would have little effect upon the index. The tendency would be to

smooth the index. It would be slightly lower in the period 1924-1929, slightly higher in 1932, and slightly lower in 1936. As a measure of purchasing power it would be more accurate than the index number of prices of commodities but not very different.

PUBLIC HEALTH IN CALIFORNIA—1937-1938 *

Since the last meeting of this organization public health conditions, in so far as communicable disease control is concerned, have reflected great credit upon local health authorities. Diphtheria and typhoid fever were lower in prevalence last year than at any time in the history of the state. Animal rabies was more prevalent than for many years and there were no less than three human deaths from this disease. The St. Louis type of epidemic encephalitis appeared in California—the first time that it has been encountered west of the continental divide. More than 100 cases, 40 per cent of which were in the younger age groups, were investigated by the California State Department of Public Health. No other major outbreaks of communicable diseases were reported.

Migratory agricultural laborers in the San Joaquin Valley, particularly, caused considerable concern to many governmental agencies and unofficial organizations as well. Typhoid fever and smallpox appeared among these laborers, but through the intervention of local officers, assisted by state employees, all outbreaks of these diseases were brought under control and many thousands of workers were immunized.

Plague was demonstrated in rodents and in fleas taken from a wide variety of rodents during the past year. There seems to be no specific geographical area to which plague infection is confined. It is encountered at high elevations and at sea level, in the northern as well as southern areas of the Pacific slope. There are many seemingly paradoxical findings in rodent plague which will be discussed by Doctor Meyer in his paper to be presented this morning. No human cases of the disease have occurred in California since our meeting of last year.

The development and growth of the program for the control of venereal diseases is an outstanding feature in the progress of public health. Some of the most conspicuous accomplishments are indicated in the following facts:

1. Efficiency in reporting cases of venereal disease has improved greatly. There was an increase of 44 per cent in 1937 and during the first half of 1938 there is an indicated increase of 50 per cent over 1936. In February of 1937, the month that the State Bureau of Venereal Diseases was reorganized, there were 889 cases of gonococcus infection reported and in June of 1938 no less than 1,514 such cases were reported. Syphilis reports increased from 828 in February of 1937 to 2,335 in June of 1938.

2. During the two years ended June 30, 1938, treatments administered in cases of syphilis and gonococcus infection totaled 878,679. Of these, 329,165 were given during the first year of the biennial period and 549,514 during the second year.

3. The number of blood tests for syphilis performed in the State Bacteriological Laboratory increased from 3,416 in July of 1936 to 10,063 in June of 1938.

4. Public health nurses employed by the Bureau of Venereal Diseases during the four months ending with June, 1938, located sixty-nine sources of infection, 411 contacts and 1,082 cases in which treatment had lapsed.

There is food for thought in the statement that if the same morbidity rate for syphilis had prevailed in California last year as prevailed in Sweden in 1934 there would have been only 457 reported cases in the state instead of 17,282 cases reported.

It is admitted, generally, that the educational campaign carried on by official, and also unofficial organizations throughout the United States, has accomplished as much in the improvement of general health conditions as it has in the relief of tuberculosis. Since the tuberculosis campaign originally was based largely upon education in the rules of hygiene, it would seem that the campaign for the control of syphilis, because of its greater complexity, may be productive of more extensive results in providing the general public with exact scientific information relative to the major infectious diseases, their modes of treatment and methods of control. The individual who acquires specific information relative to the infectiousness of syphilis is likely to acquire reliable information relative to the communicability and control of most other infectious diseases. If successful, such a campaign will go far toward the establishment and maintenance of confidence in all public health procedures.

Also, the attitude of the health officer toward the venereal disease campaign may have a very direct bearing upon the success of all other activities that may be conducted by his department. The public relations program must, of necessity, vary according to the status of public opinion in the various local communities. Nevertheless, a definite stand in matters related to the control of venereal diseases must be taken by every health officer. Full support should be given to the program everywhere.

At the present time no less than 81½ per cent of the population of California is under the administration of whole-time public health service. Twenty-four counties (including San Francisco City and County) and ten municipalities have public health departments whose employees devote their whole time to the duties of their respective offices. Since the last meeting of the Health Officers' Section the Fresno City Health Department has been reorganized upon a whole-time basis and the counties of Solano, Sonoma and Tulare have joined the ranks of those employing whole-time county health units.

Any review of public health in California during the past year must, of necessity, give recognition to new demands for service that have led to the alteration or expansion of old programs and the development of new procedures in public health administration. There has come a general growth in those services that are not directly concerned with the control of communicable diseases. To be sure, there has been no gap in the practice of procedures for immunization against smallpox and diphtheria, which must always be regarded as standard in any official public health program. The low incidence of these and other diseases indicates that local health officers throughout most of the state have not neglected their activities in the prevention and control of communicable diseases.

There is a marked tendency, however, to regard the human being as a social unit in the structure of government rather than as a group of cells under control of biological laws. Of course, those factors that have to do with heredity, physical growth, resistance to disease and immunity are still existent. There has come no sudden biological transformation in the human being, but he has become regarded today, more than ever before, as a patient rather than as a case.

Services that have heretofore been denied to a large proportion of citizens are now readily available. More intensive and incessant demands, in fact, may extend our public health program into new fields, such as control of cancer and other chronic diseases through treatment, more effective and more extensive education in healthful living, broad social services and activities that may even be undreamed in the light of our present knowledge.—*Bulletin*, California Department of Public Health.

* W. M. Dickie, M. D., Director California State Department of Public Health.

Read before the Health Officers' Section, League of California Municipalities, Santa Barbara, September 6, 1938.

AN INVESTIGATION OF THE NARCOTIC EVIL *

Mr. Coffee of Washington: Mr. Speaker, this bill proposes an appropriation for making a survey of narcotic-drug conditions in the United States.

A question naturally arises as to why such a survey is desirable. The answer cannot be given without first gaining

* Speech of Hon. John M. Coffee of Washington, in the House of Representatives, Tuesday, June 14, 1938.

A discussion of House Joint Resolution 642, to provide for a survey of narcotic-drug conditions in the United States by the Public Health Service. Introduced by Mr. Coffee of Washington, April 7, 1938. Referred to the Committee on Interstate and Foreign Commerce and ordered to be printed.